IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF WEST VIRGINIA

CHARLESTON DIVISION

JOHN BROWNING,

Plaintiff,

v. CIVIL ACTION NO. 2:00-0461

A.T. MASSEY COAL COMPANY EMPLOYEES' COMPREHENSIVE BENEFIT PLAN, and MADELINE CURLE,

Defendants.

ORDER

Pending before the court is (1) the plaintiff's Motion for Summary Judgment and Request for Sanctions pursuant to the Employee Retirement Income Security Act (ERISA), and leave to exceed the 20-page limit [docket # 20]; (2) the defendant's Motion for Summary Judgment [docket #18], and (3) the plaintiff's Motion to Strike [docket # 30]. For the following reasons, the court **GRANTS** the plaintiff's motion for summary judgment and leave to exceed 20 pages; **DENIES** the plaintiff's motion for sanctions; **DENIES** the defendant's motion for summary judgment; and **GRANTS** the plaintiff's motion to strike.

I. Background

Plaintiff John Browning worked as an electrician for Vantage Coal Company (Vantage), a division of Rawl Sales & Processing, which is a subsidiary of A.T. Massey Coal Company, Inc. At Vantage, Browning was a participant in the defendant A.T. Massey's Coal Company

Employees' Comprehensive Benefits Plan (the Plan). The Plan provides long-term disability benefits to participants who meet the Plan's definition of "disabled." The Plan defines "disability" as a "condition that can be expected to result in death or to be of long, continued, and indefinite duration, which condition renders an individual unable to perform *the regular duties of his job*, and which condition exists by reason of any medically determinable physical or mental impairment." A.R. 19 (emphasis added).

Browning is 61 years old. He has worked in the coal mines for more than 31 years, most recently as chief electrician. On July 9, 1997, Browning was lifting and dragging a belt cross-walk over a conveyor belt when he felt a sharp pain in his upper back, left shoulder, and in his lower back and hips. He continued to work the rest of his shift. On July 11, 1997, Browning informed Vantage that he could not work because of extreme pain in his back and hips, and went to the hospital for treatment. A Vantage superintendent asked him to come to work and answer phones as "light work" so that Vantage would not have to report an extended lost time accident. A.R. 107. Browning tried to perform the "light duty" tasks, but continued to experience pain and medical problems. Around the same time, Browning saw his treating physician, Dr. Nilkhanth Purohit, and numerous specialists doctors, and received several excuses and return to work dates from Dr. Purohit. In August 1997, Vantage informed Browning that it could not allow him to work because of the medications he was taking. Browning received salary continuation benefits for the next six months under the Plan.

On January 20, 1998, Browning filed a claim for long-term disability benefits with the Benefits Committee. He submitted a number of medical records with his application. The Plan provides a maximum of 180 days for the Benefits Committee to review and resolve a claim for

benefits. A.R. 312. On January 23, 1999, just over a year after Browning filed his application for disability benefits, the Benefits Committee denied Browning's claim because he did not meet the Plan's definition of disability because his impairments did not prevent him from performing his job duties. The denial letter did not include a description of Browning's job duties or explain how he could perform his job duties.

Browning appealed that decision and requested a description of his job duties. The Benefits Committee did not respond to Browning's request for the documents, and on May 27, 1999, the Committee affirmed its initial decision. A.R. 89-100. The denial letter states that the Committee reviewed Browning's claim with two independent doctors, Dr. David Cifu and Dr. Herbert Park, and that Dr. Cifu concluded that Browning could perform all the essential elements of the job of chief electrician. The Committee did not include in the administrative record medical reports from the independent doctors.

On May 3, 2002, this court held a hearing on the current motions and ordered the defendant to submit the missing independent medical reports. On May 17, 2002, the defendant submitted a medical report by Dr. Cifu which indicates that Dr. Cifu relied on a job description for "DOT Maintenance Supervisor (638.131-034)" in concluding that Browning could perform all the "essential elements of his job duties." Def.'s Ex. Accomp. Mem. [docket # 29], *see also* A.R. 90. As stated earlier, Browning's correct job description was for third shift chief electrician. The defendant also submitted an affidavit by the plan administrator, minutes of the Benefits Committee Meeting reviewing Browning's claim, and a "medical disability advisor form."

Browning now seeks review of the decision denying his claim for disability benefits and requests this court to impose penalties on the defendant for its failure to provide the denial notice within the time required by the Plan and its failure to provide him with a copy of his job description.

II. Standard of Review

A motion for summary judgment may be granted when there are no genuine issues of material fact and the movant is entitled to a judgment as a matter of law. *Fed. R. Civ. P.* 56(c); *Matsushita Elec. Indus. Co., Ltd. v. Zenith Radio Corp.*, 475 U.S. 574, 587-88 (1986). Summary judgment is appropriate when the nonmoving party has the burden of proof on an essential element of his case and does not make, after adequate time for discovery, a showing sufficient to establish that element. *Celotex Corp. v. Catrett*, 477 U.S. 317, 322-23 (1986). The nonmoving party must satisfy this burden of proof by offering more than a mere "scintilla of evidence" in support of his or her position. *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 252 (1986).

In reviewing an ERISA claim for the denial of benefits, the court must apply a de novo standard unless the benefit plan provides the plan administrator or fiduciary with the discretionary authority to determine eligibility for benefits or to construe the terms of the plan. *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989). If the Plan provides the plan administrator with discretionary authority, the court applies an "abuse of discretion" standard, and will not disturb the denial of benefits if the decision is objectively reasonable and based upon substantial evidence. *Firestone*, 489 U.S. at 111; *Ellis v. Metro Life Ins. Co.*, 126 F.3d 228, 232 (4th Cir. 1997); *Brogan v. Holland*, 105 F.3d 158, 161 (4th Cir. 1997). Here, the Plan gives the fiduciary the discretionary authority to determine eligibility for benefits, and to construe all terms

of the Plan. A.R. 265, 331 ("Using its discretion, the Administrator must determine whether or not an Employee is an Eligible Employee . . . .").

A modified abuse of discretion standard is applied where the plan administrator operates under a conflict of interest. *Doe v. Group Hosp. & Med. Srvs.*, 3 F.3d 80, 84 (4th Cir. 1993). Here, the Plan is funded by A.T. Massey, appoints A.T. Massey as its fiduciary, and is administered by the Benefits Committee, which is a division of A.T. Massey. A.R. 46. The mailing address for the Benefits Committee is listed at the same address as A.T. Massey, and the Plan provides that all correspondence should be mailed to the Benefits Committee c/o A.T. Massey. *See id.* All voting members on the Benefits Committee are either employees of A.T. Massey or employees of one of its subsidiaries. Under these circumstances, the court finds that a conflict of interest is present and will weigh that factor in determining whether there was an abuse of discretion, and accord less deference to the administrator's decision to the degree necessary to neutralize any untoward influence resulting from the conflict. *See Ellis*, 126 F.3d at 233; *Doe*, 3 F.3d at 87.

III. Outside Evidence

Because the appropriate standard of review is modified abuse of discretion, this court is limited to the evidence that was before the plan administrator at the time of the decision. *See Bernstein v. CapitalCare, Inc.*, 70 F.3d 783, 788 (4th Cir. 1995). Because the administrative record should have included a copy of the medical reports of the independent doctors who reviewed Browning's claim and who were cited in the Committee's letter affirming the denial, this court issued an order requesting the same. In response, the defendant filed the medical report

of Dr. Cifu, an affidavit by the plan administrator, the minutes of the Benefits Committee's Meeting from May 14, 1999, and a medical disability advisor form.

Plaintiff has moved to strike the affidavit of the plan administrator, the minutes of the Benefits Committee, and the medical disability advisor document [docket # 30] because they are outside the scope of the court's May 3, 2002 order. The court has reviewed these outside documents and finds that the affidavit, the medical advisor form, and the minutes are not properly part of the administrative record. First, it was the defendant's responsibility to compile a complete and accurate administrative record when it submitted it to this court on October 5, 2001. A medical disability advisor form was not submitted as a part of that record. At this late stage, where questions have been raised as to the quality of the review, the defendant cannot seek to introduce that piece of evidence. Second, the self-serving affidavit of Ms. Curle prepared for litigation does not aid this court in performing its review of the claim or in determining if a conflict of interest is present. It is therefore excluded. Finally, the court excludes the minutes of the Benefits Committee. If the minutes were actually part of the administrative record, the defendant was obligated to submit them on October 5, 2001, as part of the administrative record submitted to this court. Accordingly, the court **GRANTS** the plaintiff's motion to strike.

IV. The Merits

The court has reviewed the administrative record and finds a clear abuse of discretion by the plan administrator. The evidence in the administrative record, some of which was submitted only at the court's insistence, convinces this court that the Committee acted in an adversarial manner designed to reach a specific outcome. Procedurally, the Committee stalled the review of the claim for no good reason, and failed to provide correct or complete information to the doctors

and to this court. Finally, in issuing its denial letter and affirming that denial, the Committee selectively and misleadingly excerpted quotations from medical reports, and ignored the bulk of medical evidence supporting plaintiff's claim. The court **FINDS** that the Committee acted unreasonably when it found that the plaintiff could perform the regular duties of his job.

A.

ERISA sets out minimum fiduciary and disclosure requirements which every pension plan must meet. *See Blau v. Del Monte Corp.*, 748 F.2d 1348, 1352 (9th Cir. 1984) (citing H.R. Rep. No. 533, 93d Cong., 2d Sess., reprinted in 1974 U.S. Code Cong. & Ad. News 4639). ERISA mandates a reasonable claims procedure, 29 U.S.C. § 1133, and the Code of Federal Regulations establishes what will be considered reasonable:

> (b) A claims procedure will be deemed to be *reasonable only* if it:
>
> > (1) complies with the provisions of . . . this section . . . .
> > (2) is described in the summary plan description . . . ,
> > (3) does not contain any provision, and is not administered in a way, which unduly inhibits or hampers the initiation and processing of plan claims, and
> > (4) provides for informing participants in writing, in a timely fashion, of the time limits.

29 C.F.R. § 1133 (emphasis added). Accordingly, a reasonable review requires that claims must be processed in accordance with the time-frame set out by the Secretary of Labor. *See* 29 C.F.R. § 2560.503-1(f). Where fiduciaries deny a claim, they must state the specific reason(s) for their denial and provide the specific plan provision that forms the basis of a denial. 29 U.S.C. § 1133; 29 C.F.R. § 2560.503-1(g); *Weaver v. Phoenix Home Life Mut. Ins. Co.*, 900 F.2d 154, 157 (4th Cir. 1993). Fiduciaries must provide the reasons for the denial in writing and in language likely

to be understood by the claimant. 29 U.S.C. § 1133; 29 C.F.R. § 2560.503-1(g); *Grossmuller v. Int'l Union*, 715 F.2d 853, 858 (3d Cir. 1983).

By implementing these and other procedural requirements, Congress ensured that plan administrators would perform "full and fair reviews" of claims, and uphold the administrative integrity that is essential to this administrative scheme. *Fort Halifax Packing Co., Inc. v. Coyne*, 482 U.S. 1, 15 (1987); *Weaver*, 990 F.2d at 157. Where a fiduciary neglects these responsibilities, courts generally find an abuse of discretion. *Weaver*, 990 F.2d at 159. The court notes the following prejudicial irregularities.

1. Time-Frame in Deciding and Reviewing Browning's Claim

For disability claims, ERISA requires that plan administrators notify the claimant with an adverse benefit determination no later than 45 days after receipt of the claim, and if appropriate notice and explanation is provided for each 30-day extension request, no later than a maximum of 105 days. 29 C.F.R. § 2560.503-1(f)(3).[1] Here, the Benefits Committee received Browning's claim on January 28, 1998, and denied it on January 23, 1999 – 361 days after it received Browning's claim. 361 days is unquestionably outside the Secretary's prescribed maximum 105-

[1]This period may be extended for two additional 30-day periods only if the plan administrator determines that the extension is necessary due to matters beyond the plan administrator's control and for each extension, notifies the claimant prior to the expiration of the initial 45-day period (or prior to the end of the first 30-day extension) of the circumstances requiring the extension and the date by which the plan administrator expects to render a decision. *Id.*

Any notice of extension "shall specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues." *Id.* The period of time is determined without regard to whether all the information necessary to make a benefit determination accompanies the filing. *Id.* Although the Committee's initial denial was clearly untimely and beyond all allowable extensions, the Committee made no attempt to notify Browning in the interim period or explain why its initial letter was out-of-time.

day time-frame for a disability benefits claim. *See* 29 C.F.R. § 2560.503-1(f)(3). The court also notes that the defendant's Plan indicates a time-frame for resolving all benefit claims, whether involving disability or other types of determinations, that is contrary to ERISA. The defendant's Plan provides for a 90 to180 day time-frame review policy, as opposed to the Secretary's 45 to 105-day maximum time-frame. *See* A.R. 313. The court finds that the Plan's own terms are misleading and failed to provide Browning with appropriate notice that he had a right to a more timely determination.

The Committee's subsequent affirmation of that denial also was untimely. ERISA provides that a plan administrator must notify a claimant of a disability benefit determination on review no later than 45 days after receipt of the claimant's appeal. 29 C.F.R. § 2560.503-1(i)(3). The Committee received Browning's notice of appeal on February 19, 1999. The Committee sent Browning a letter dated April 30, 1999, acknowledging receipt of his notice of appeal, and informing him of an extension of time to review the determination, and that the Committee expected to decide the claim no later than 60 days from April 30, 1999.

ERISA provides for a maximum of 90 days to review such a claim *when* the plan administrator, prior to the termination of the initial 45-day period, determines that special circumstances warrant additional time and notifies the claimant of the need for an extension of time prior to the termination of the initial 45-day period. *Id.* § 2560.503-1(i)(1) & (3). Here, the Committee sent Browning a notice of extension 71 days after Browning sent notice of his appeal. The notice does not indicate any special circumstances requiring more time: the review was performed without a hearing and the same committee performed the initial review and the appellate review. This notice of extension was therefore untimely and insufficient.

On May 27, 1999, the Committee sent a written letter to Browning, affirming its earlier denial of benefits. A.R. 89. This letter was sent 98 days after the Committee received Browning's notice of appeal, and in any event violates ERISA's prescribed time-frame. *See* 29 C.F.R. § 2560.503-1(i)(1) & (3) ("In no event shall such extension exceed a period of [45] days from the end of the initial period.").

2. Failure to Provide Requested and Correct Information

Because the Plan's definition and application of disability turns on the individual's particular job description, the job description's relevance to Browning's claim cannot be questioned. The defendant refused to provide Browning with a copy of this document upon his request, thus preventing him from more fully addressing the issues in his denied benefits claim. The defendant asserts that due to clerical error, the medical reports of Dr. Cifu and Dr. Park were not submitted with the administrative record. After this court's order requesting the same, it became apparent that Dr. Park did not issue a written medical opinion regarding Browning's claim at all, and that the sole job description given to Dr. Cifu was for the wrong job, that of a maintenance supervisor and not Browning's third shift chief electrical engineer position.

3. Overall Effect of Procedural Irregularities

A plan administrator's adherence to ERISA's procedural safeguards ensures that plan administrators perform their fiduciary duties in the sole interest of plan participants. 29 U.S.C. §§ 1001(b) & 1104(a)(1); *Makar v. Health Care Corp. of the Mid-Atlantic*, 872 F.2d 80, 83 (4th Cir. 1989). Plan administrators must adhere to their fiduciary duties rigorously, in both their administration of claimants' benefits applications, and in the substantive review of such claims.

Here, the plan administrator's failure to exercise these duties has had a substantive and prejudicial effect on Browning's claim for disability.

B. Abuse of Discretion

Browning asserts that the Benefits Committee abused its discretion by finding that he did not meet the Plan's definition of "disability" under the plain terms of the Plan. Browning argues that the Benefits Committee ignored evidence supportive of his claim, and based its denial on portions of the medical evidence taken out of context.

The Plan provides that an employee is disabled when he is unable to perform the regular duties of his job. A.R. 19. Browning's job description states:

> The physical demands described here are representative of those that must be met by an employee to successfully perform the essential functions of his job . . . . While performing the duties of this job, the employee is regularly required to walk, talk, see, and hear. The employee frequently is required to stand and use his hands to finger, handle, or feel objects, tools, or controls. The employee is occasionally required to sit, reach with hands and arms, climb and balance, and stoop, kneel, crouch, or crawl. The employee must occasionally lift or move up to 50 pounds.

A.R. 10 (emphasis added). The Committee's denial letter did not include the language from Browning's job description. Instead, after providing a bullet-point list of selected excerpts from medical reports, the letter concluded that the diagnoses, medical tests, notes, and examination results were "compelling" and supported its finding that Browning did not meet the definition of disability. A.R. 24-25.[2] The Committee relies not on any one doctor's opinion in finding

[2]In its denial letter, the Committee based its determination on opinions submitted by Browning's treating physician, Dr. Purohit; a neurologist referral, Dr. William Curtin; a general thoracic and vascular surgeon, Dr. William Walton; a neurosurgeon, Dr. Hossein Sakhai; a neurologist, Dr. William Robertson, Jr.; a cardiovascular disease specialist, Dr. Shahbaz Mian; and (continued...)

Browning not disabled under the Plan, but on selected phrases from various medical reports and documents. Such selective quotation does not amount to a reasonable basis for the denial of benefits. *See Pinto v. Reliance Ins. Co.*, 214 F.3d 377, 393-94 (3d Cir. 2000) (finding that the plan administrator's written decision employed a self-serving selectivity in the medical evidence it considered); *Salley v. E.I. Dupont de Nemours & Co.*, 966 F.2d 1011, 1015 (5th Cir. 1992) (rejecting the plan administrator's crediting one part of the advice of a treating doctor, but not his other advice); *Lasser v. Reliance Standard Life Ins. Co.*, 130 F. Supp. 2d 616 (D.N.J. 2001) (same).

The court finds that the record does not reasonably support the plan administrator's finding that Browning is not disabled. Dr. Purohit appears to be the only physician in the record who evaluated Browning based on the sum total of his impairments, and who examined plaintiff's job duties in light of those impairments. Dr. Purohit found that Browning suffered from, among other conditions, angina pectoris, sciatica arthritis, and vascular conditions of a serious nature and concluded that Browning was unable at the present time or in the near future to fulfill all of his job obligations. A.R. 238. The defendant dismissed Dr. Purohit's findings, briefly stating in its letters that Dr. Purohit did not indicate which job duties Browning could not perform, and that he did not submit documentation supporting his findings. A.R. 24. The court notes that Dr. Purohit treated the plaintiff over a number of years, was responsible for referring

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[2](...continued)
a physical therapist, Linda Cox.

In the letter affirming the denial, the Committee cites to a physical medicine and rehabilitative specialist, Dr. Prasadarao Mukkamala; a cardiac, thoracic, and vascular surgeon, Dr. M. Kahn; an orthopedic surgeon, Dr. Charles Combs; and two independent physical medicine and rehabilitative specialists, Dr. David Cifu and Dr. Herbert Park.

Browning to various specialists, and reviewed all the specialists' reports before making his determination. The record amply supports Dr. Purohit's findings.

Dr. Mukkamala, who met with and evaluated Browning for his complaints of shoulder and back pain, diagnosed Browning with theracolumbar strain. A.R. 114. He also noted that Browning had reached a maximum degree of medical improvement and that he would be able to work only in a light/medium category of work provided that he avoid frequent bending and twisting of his back. A.R. 116. The Committee, however, ignored Dr. Mukkamala's diagnosis and conclusions, acknowledging only:

> You were examined by Prasadarao B. Mukkamala, M.D. (Physical medicine and rehabilitation specialist) this date [1/14/99]. Regarding your left shoulder, he notes, 'The claimant mentioned that he injured his left shoulder, but physical examination of the left shoulder was normal and thereby there was no permanent impairment with reference to the left shoulder.'
> . . .
>
> *The Benefits Committee notes that no medical documentation indicates that you are Disabled or unable to work at your job because of your shoulder problem*."

A.R. 95 (emphasis added by the Benefits Committee).

While Dr. Mukkamala's findings regarding Browning's shoulder are evidence that his shoulder pain does not support a finding of disability, Dr. Mukkamala's overall findings regarding Browning's *back injury* are clearly pertinent to whether Browning could perform his job duties. Dr. Mukkamala unequivocally determined that Browning could not perform a job which required bending and twisting his back. A.R. 116. Browning's job duties required stooping, kneeling, crouching, and crawling. A.R. 10. Thus, Dr. Mukkamala's opinion supports

a finding that Browning can not bend or twist, and thus can not perform the regular duties of his job. The Committee did not address this part of Dr. Mukkamala's finding.

The Committee also cites portions of Dr. Curtin's findings in its denial letters, selectively excluding Dr. Curtin's final determination which supported a finding that Browning could not perform tasks that were a part of his regular job duties. After a full evaluation, Dr. Curtin determined that Browning suffered from "degenerative low back syndrome," and noted that

> often these symptoms of 'low back strain' are recurrent and more chronic in nature, being readily exacerbated, as in Mr. Browning's case, by bending or lifting, suggesting that postural, muscular or arthritic factors play a major role. This is the most common syndrome seen by neurologists and orthopedic surgeons, more in men than in women. As in Mr. Browning, after some unusual activity, raising the question of trauma, especially if it happens in the workplace, the patient develops deep aching pain in the low back, increased by certain movements and attended by stiffness.. (emphasis added by Dr. Curtin)
> . . . .
>
> It is notable that your inquiry letter, dated 4 February 1998, arrived eight months and 13 days after I last evaluated Mr. Browning on one isolated occasion. Thus, in regard to many of the questions posed in your communication on 4 February 1998, I am unable to properly answer, since I have no idea as to his current medical symptoms. . . . To the best of my knowledge, however, represents a one-time evaluation on 22 July 1997, and certainly, if you wanted more accurate, up-to-date information, you would have requested Mr. Browning to come back to me for reassessment, at least over the course of the last few weeks.

A.R. 243-44.

Despite Dr. Curtin's advisory that his opinion was likely outdated, the Committee did not refer Browning for a follow-up visit with Dr. Curtin. The Committee ignored Dr. Curtin's overall findings and express caveat that his findings were limited to an out-dated, one-time visit. Dr. Curtin clearly states that Browning suffers from pain in his back, which is exacerbated by bending and lifting, and that such symptoms were recurrent and chronic in nature. A.R. 244. In

light of Dr. Curtin's overall conclusion and admitted lack of knowledge as to Browning's current state, the Committee's reliance on his opinion is questionable.

The Committee also cites portions of Dr. Hossein Sakhai's findings from an examination performed on September 11, 1997. The Committee quotes:

> "On examination he had satisfactory range of motion in the lumbosacral area. No weakness was noted on either leg. Deep tendon reflexes were present. Straight leg raising was essentially negative." Further, he stated, "With this examination it appeared Mr. Browning has made **fairly satisfactory recovery from the lumbar strain that he had in July.** I did not feel any specific neurological intervention, or any other treatment, was necessary at this time. **He should be able to return to work starting next week without restriction**."

A.R. 23, 93 (emphasis added by the Benefits Committee). The Committee, however, failed to note Dr. Sakhai's notation that at the time of his visit with Browning, he had not been working, and that Browning stated that "when he is not working he has no pain, but when he is active he may have some discomfort in the low back region." A.R. 229. Moreover, Dr. Sakhai's findings were from an evaluation performed on September 11, 1997. The Committee does not acknowledge that Dr. Sakhai's limited finding based on a neurological evaluation conflicts with Dr. Mukkamala's and Dr. Purohit's more recent findings based on in-person, complete evaluations as to Browning's back injury. While the Committee emphasizes Dr. Sakhai's conclusion that Browning should be able to return to work without restriction, the record demonstrates that at the time he made that determination, Dr. Sakhai's determination did not take into account Browning's other impairments or the specific requirements of his job duties. A.R. 229. Thus, Dr. Sakhai's medical report alone does not support the defendant's finding that Browning is able to perform the regular duties of his job.

The Committee also cites a portion of Linda Cox's findings, a physical therapist who treated Browning over an extended period of time. The denial letters quote:

> Patient was discharged on **12/16/97** with a home exercise program. She further states, "can walk on level surfaces for short periods of time without any significant long term effects. Pt. can perform activities which do not require any prolonged sitting or lumbar flexion in [sic] which do allow for frequent position changes."
> . . .
>
> *The Benefits Committee addressed the office visits notes, physician reports, and diagnostic testing on your back in great detail. The Benefits Committee found the above documentation particularly convincing that you are not Disabled due to your back condition.*

A.R. 24, 93 (emphasis added by the Benefits Committee).

The Committee ignored the portion of Ms. Cox's findings which states that Browning suffered from "Lumbar strain with left Sciatica;" that he had "[p]ain in his left hip with all lumbar movements;" that he had "increased pain with repeated lumbar Fl. activities, pain with palpitation L5, S1;" "At this time patient is unable to perform activities requiring Fl. of lumbar spine, repeated or over a long period of time;" and that Browning "has not responded to physical therapy at this time." A.R. 249. These statements by Ms. Cox are clearly relevant to whether Browning can perform the regular duties of his job, yet the Committee selectively ignored such findings.

The court notes that the Committee's first denial letter does not address Browning's left-hand injury. The second letter briefly states:

> In regard to your letter, the Benefits Committee notes that you worked from 12/95 through 7/97 following your 1995 injury to your finger. You addressed that you have difficulty holding a sheet of paper, which requires very fine pinching skills. We note that this is different from holding a tool. The Benefits Committee notes

> that the documentation indicates that your injured finger is on your left hand and that you are right-hand dominant.
> . . .
>
> *The Benefit Committee notes that no medical documentation indicates that you are Disabled or are unable to perform your job because of your finger problem. To the contrary, Dr. Combs indicates that you report you are doing well at work.*

A.R. 95 (emphasis added by the Benefits Committee).

The Committee does not cite the portion of Dr. Combs's findings which states that: "Aside from his motion being 50% normal in his index and middle fingers he also has about 50% of his grip strength. At this time I believe he has reached maximum medical improvement from his injury and he could be a candidate for a permanent partial disability rating." A.R. 137. Dr. Combs's findings and reports spanning more than four months clearly indicate that Browning has a permanent injury in his left hand which prevents him from full use of his fingers and ability to grip objects. A.R. 123-137.

The Committee's unreasonable manner of resolving Browning's claim is reflected in its non-medical determination that Browning's injury prevents him from exercising fine-pinching skills, which, in its view, does not affect his ability to grip, and thus, perform his job. A.R. 95. Browning's job description requires that he frequently be able to use his hands to finger, handle, or feel objects, tools, and controls. A.R. 10. The court also notes that Dr. Combs determined that Browning had only 50% of his grip strength in his left hand. A.R. 137. The court finds that the Committee's dismissal of Dr. Combs's findings and supporting medical documentation do not reflect the actions of an unconflicted fiduciary performing a full and fair review.

The Plan states that Browning shall be considered disabled if he cannot perform the *regular duties of his job*. As chief electrician, Browning is "regularly required to walk, talk, see, and hear. The employee is required to stand and use hands to finger, handle, or feel objects, tools, or controls. The employee is occasionally required to sit, reach with hands and arms, climb and balance, and stoop, kneel, crouch, or crawl. The employee must occasionally lift and/or move up to 50 pounds." A.R. 10. The Committee's determination and explanation of that determination should have expressly focused on whether an unbiased application of the evidence supported a finding that Browning could competently perform these tasks. The Committee failed to perform this type of review.

The court finds that the Benefit Committee's determination was not objectively reasonable. *See Ellis*, 126 F.3d at 233. The Committee was required to perform its review "solely in the interest of the participants and beneficiaries and for the exclusive purpose of providing benefits." *Firestone*, 489 US. at 154. Indeed, the human resources manager for Vantage indicates that there are *no* jobs which Browning could perform at Vantage. A.R. 72.

In sum, the initial denial and its later affirmation by the Benefits Committee reveal an improperly adversarial approach to the review of medical evidence. The initial denial is replete with inconsistencies between the Committee's analysis and the underlying medical records. The Benefits Committee's shortcomings were exacerbated by providing Dr. Cifu with the wrong job description, a document central to its analysis, and by failing to provide the plaintiff with a copy of this relevant document to prepare for this review. The plaintiff was deprived of his right to a full and fair review, and the court accords little deference to the defendant's determination. The court **FINDS** that there are no genuine issues of material fact and that the Benefits Committee

clearly abused its discretion. The court therefore **DENIES** the defendant's motion for summary judgment, and **GRANTS** the plaintiff's motion for summary judgment.

V. Penalties

Browning also requests this court to impose a penalty for the defendant's failure to provide a copy of his job description and its failure to decide the plaintiff's claim in a timely manner.

A. Failure to Provide Job Description

ERISA requires an administrator "upon written request of any participant or beneficiary, [to] furnish a copy of the latest updated summary plan description, plan description . . . contract, or other instruments under which the plan is established or operated." 29 U.S.C. § 1024(b)(4). Section 1132(c)(1) provides:

> Any administrator . . . (B) who fails or refuses to comply with a request for any information which such administrator is required by this subchapter to furnish to a participant or beneficiary . . . by mailing the material requested to the last known address of the requesting participant or beneficiary within 30 days after such request may in the court's discretion be personally liable to such participant or beneficiary in the amount of up to $ 100 a day from the date of such failure or refusal, and the court may in its discretion order such other relief as it deems proper.

Here, despite plaintiff's written request for a copy of his job description, the administrator did not provide a copy until the filing of the administrative record in this court.

In *Faircloth v. Lundy Packing Co.*, the Fourth Circuit interpreted the meaning of "other instruments" in section 1024(b)(4), and found that such language encompassed only formal or legal documents under which a plan is set up or managed. 91 F.3d 648, 653 (4th Cir. 1996). Penalties therefore may be imposed only if the plaintiff's job description is a formal, legal

document under which the plan is set up or managed. *See id.*; 29 U.S.C. § 1024(b)(4). The court finds that plaintiff's job description is not a formal, legal document used to set up or manage the plan as contemplated by *Faircloth*. The court **DENIES** plaintiff's request for sanctions on this ground.

B. Failure to Decide Claim in a Timely Manner

ERISA requires plan administrators to complete claims handling within the time limits prescribed by the Secretary of Labor. 29 C.F.R. § 2560.503-1(e). Delay in the processing of an application or appeal does not, however, give rise to a private right of action for punitive relief. *Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 144 (1985). Under *Russell*, the Supreme Court clarified that the appropriate response to an untimely review is for the plaintiff to bring an action in court to have the merits of his application determined, not request penalties. *See id.* Therefore, the court **DENIES** the plaintiff's request for penalties as a result of the plan administrator's failure to process his claim in a timely manner.

VI. Conclusion

For the reasons stated above, the court **GRANTS** the plaintiff's motion for summary judgment and leave to exceed 20 pages; **DENIES** the plaintiff's motion for sanctions; **DENIES** the defendant's motion for summary judgment; and **GRANTS** the plaintiff's motion to strike.

The court **DIRECTS** the Clerk to send a copy of this Order to counsel of record and any unrepresented party.

ENTER: June 26, 2002

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JOSEPH R. GOODWIN
UNITED STATES DISTRICT JUDGE